ATTACHMENT B

PSYCHOLOGICAL STATUS FORM

Patient: _____DOI: _____ DCD Case No.: _____
Carrier Claim No.:_____

1. Diagnosis (DSM) (provide attachments as necessary)

2. Is this the initial report? Yes ___ No ___

3. If not, has functional status changed from the last report? (Describe changes)

___ much improved _____
___ minimally improved _____
___ no change
___ minimally worse _____
___ much worse _____

4. Did the mental disorder under treatment arise out of or was exacerbated in the course of employment? Yes ___ No ___ Undetermined ___

5. Can the patient return to work? Yes ___ Patient's return to work date _____
No ___ Patient's last work day prior to disability _____

6. If the patient is unable to return to work, are there limitations in performing usual and customary work due to a mental disorder related to the industrial injury?
Yes ___ No ___ Undetermined ___
If "yes", please identify the limitations.

Is the patient able to return to their usual and customary work at a different work site?
Yes ___ No ___ Undetermined ___

7. Are there other factors that may affect work performance (e.g. frustration, anger, etc.) that are not part of the industrial mental disorder injury? Yes ___ No ___ Undetermined ___

   If yes, are these other factors the reason the patient is unable to return to work? Please identify these factors and explain.

8. Prognosis: Excellent ___ Good ___ Fair ___ Poor ___ Uncertain ___

9. At maximum medical improvement? Yes ___ No ___Estimated Date _____

10. Comments:

Signature: _____ Date: _____

Print Name: _____Phone: _____